Arizona Department of Health Services/ Office for Children with Special Health Care Needs
Children's Rehabilitative Services

MEMBER PAYMENT AGREEMENT FOR NON-AHCCCS/KIDSCARE MEMBERS

Patient Name_____ **D.O.B.**_____

Children's Rehabilitative Services shall provide authorized services. My payment responsibility category will be:

☐ 0% based on AHCCCS rates

☐ 100% based on AHCCCS rates

Does patient have Medical Insurance? Yes ☐ No ☐

I agree that any moneys received by me as a court award or settlement of a claim which provides for medical care of the member shall be used to pay CRS providers for care which is authorized and provided. I agree that when insurance benefits, court awards, claim settlements or other third party benefits are available, I shall make them available before CRS funds shall be used to provide care for the member or shall be used to reimburse CRS or the CRS contractor for all care provided to the member. If I receive and convert any benefits described by this subsection to my personal use and not for payment of the member's CRS services, I shall be personally responsible for the payment of the services for which the benefits were intended to pay.

If applicable, payments will become due and payable after receipt of statement of charges. I agree to provide all information necessary to enable CRS and CRS providers to collect such insurance. I agree to notify CRS within ten (10) days of any financial or insurance changes that would affect my financial eligibility.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize CRS to release information necessary for the completion of hospital, other providers, and medical insurance claims. I also authorize CRS to exchange information with DES or AHCCCS and other insurance companies as necessary to determine financial eligibility.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize any insurance company with whom I have coverage, to make payment directly to the hospital, clinic, physician or other CRS provider rendering service. I also agree to forward any insurance moneys, received for services rendered through Children's Rehabilitative Services, to the provider of such service. I agree to send copies of all explanation of benefits received by me from my health insurance company to CRS or CRS providers.

I agree that I have been deemed eligible for CRS services at 100% based on AHCCCS rates with insurance and will be responsible for any co-pays required of me by my insurance company. Initials:_____

I certify that I have read this agreement, received a copy, and am authorized to act for the member and as his or her parent to execute and accept the terms, conditions and authorizations set out above.

Expiration Date _____

Financially Responsible Person_____ Date _____

CRS Financial Staff _____ Date of Agreement_____

STATE ONLY

Family Gross Income	**Family Total Deductions**	**Family Size**

Revised: 11/02/06